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ABSTRACT

Much of the controversy over training in diagnostic testing between internship training centers and universities results from the implicit producer-consumer relationship which exists between them. A collaborative relationship is proposed as an alternative, in which the training activities of universities and internship centers are seen as convergent rather than sequential, and universities and internship centers are related to each other through a closed loop feedback system. Assessment is conceived of as serving three different functions, and it is further proposed that allocation of responsibility for training in each of these functions between universities and internship centers should be based on the special facilities and competencies of their respective staffs. (Author)

A MULTIFACETED MODEL OF TRAINING IN PSYCHOLOGICAL ASSESSMENT

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In order to provide a context for the development of a rational and coherent approach to the problems of training in diagnostic testing, I should like to define what appear to me to be the major issues with which we must deal and also present the positions on these issues that we have been evolving at Indiana. The first issue concerns the objectives of a doctoral training program in clinical psychology. The second concerns the relationship between universities and internship training centers. And the third concerns how we conceive of the diagnostic enterprise itself.

Educational Objectives

Our educational objectives may be best presented in terms of a number of beliefs about doctoral training in clinical psychology, among which we consider the following three the most important:

First, being part of a major department and university having the talent and resources necessary to make significant contributions to our fund of scientific knowledge, we believe that we have a responsibility to make maximum use of these resources in the training of our students. Thus, we aim for the highest level of sophistication possible in our students in the design and evaluation of research, regardless of whether they opt for the scientist or practitioner route when they leave our program. We believe very strongly that it is this sophistication which most clearly sets clinical psychology apart from the other helping

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professions in its contribution to the total mental health effort.

Second, we distinguish between process and product and believe that learning to ask the right questions and how to evaluate their answers is more important in the training of psychologists than the mastery of subject matter content itself. Naturally, there are bodies of knowledge and particular skills that we believe clinical Ph.D.s should have when they leave our program, but we believe that these are likely to grow obsolete at a faster rate than the principles and methodology which led to their development.

Thus, we believe it more important that students know what is entailed in the development and standardization of tests, how to evaluate the research bearing upon them, and the principles of good clinical test administration, than it is that they should become proficient in the administration of any particular set of diagnostic tests. Proficiency can be gained on an as needed basis, if clinicians have developed the kind of process knowledge I have just described.

Lastly, we believe that universities should play a leadership role in producing the new knowledge upon which practice is based, in evaluating the effectiveness of current forms of practice, and in fostering change and innovation. Therefore, we feel it singularly inappropriate to continue providing training in assessment methods on the grounds of their popularity in the field if we have reason to believe that there are other tests and methods which will produce more useful information more efficiently. And this reflects an attitude we attempt to instill in our students, viz., that the choice of a test, assessment procedure, or form of intervention, should always be based upon knowledge of its validity and utility, to the extent that these can be empirically determined; for our graduates to fail to be governed by

these considerations in their practice is to fail in one of the most essential ways which distinguishes them from skilled technicians.

The Roles of Universities and Internship Training Centers

Concerning the roles of universities and internship centers in the training of clinical psychologists, I would propose that we have been conceiving of their relationship in terms of a linear, producer-consumer model. According to this model, the universities operate at stage one, having the responsibility for producing trainees who possess in rudimentary but usable form all of the skills necessary to function as a clinical psychologist. The internship centers operate at stage two, as consumers, whose contribution to training consists of the utilization and enhancement of the intern's university-provided skills in the context of their primary mission, which is to render service to their clientele.

Two consequences of this model for the quality of relations between internships and universities are of immediate interest. The first is that the quality of training of students when they arrive at their internships serves as a focus of controversy between university and internship-based psychologists concerning their respective conceptions of the practice of clinical psychology. A failing or lack in the new intern's skills, which cannot be easily attributed to him personally, is likely to be interpreted by the internship psychologists as reflecting his school's negative evaluation of these skills - skills which might be highly prized by the internship training staff. And similarly, the university faculty are likely to regard any criticism of their students' training by internship personnel as evidence of their obtuseness regarding the "true directions" in which clinical psychology should be

heading. This model is thus more likely to foster confrontation rather than dialogue, and conflict rather than collaboration. And perhaps nowhere is this more apparent than in diagnostic testing.

The second consequence of this model results, in part, from the internship agencies' primary service delivery mission. It is that the internships feel that they are justified in exercising their rights as consumers in asking that interns come completely equipped with those skills necessary to contribute to the center's fulfilling its service mission. And the universities generally acquiesce, either graciously or grudgingly, feeling that indeed these demands are within the internship centers' perogatives. And so, with respect to training in the Rorschach, for example, some schools say that because of the weight of scientific evidence against its validity they would drop it except that it is required by so many internships. If their students lacked this training, they would be at a competitive disadvantage. But, interestingly, reflecting their acceptance of the producer-consumer model, these schools question the value of this training, but never the legitimacy of the internship's right to establish it as a requirement for acceptance. Instead, they see themselves as victims of a kind of internship training cartel, where the balance of power appears to be the crucial issue, and where, for a change, the consumer is in the ascendance. Such are the consequences of the producer-consumer model.

The alternative to this model, I believe, is one based on a multifaceted view of both training and practice, in this case of psychological assessment. It conceives of the university and internship agency as being in a collaborative relationship with each other, with the lines of collaboration being drawn in terms of an agreement concerning the educational objectives of training in both institutions, and a careful

analysis of the various functions of the clinical psychologist, with particular attention to the question of where training in each function can be most effectively provided. This may require that university faculties relinquish or reduce some of their control over certain aspects of the pre-internship training of their students, and that internship centers, in turn, accept greater responsibility for training in many of the clinical skills and methods required for clinical practice. It also requires the establishment of truly functional channels of communication between universities and internship centers - channels which are bidirectional and which are used for communications regarding innovations and, hopefully, improvement in practice, as well as evaluations of trainee performance.

Structurally, in this alternative model universities and internship agencies are related to each other through a closed loop feedback system and their training activities are seen as convergent rather than sequential.

Diagnostic Testing

Turning now to diagnostic testing, I do not think it is much of an exaggeration to say that we may have entered what will some day be recognized as the Dark Ages of psychological assessment. We find more and more psychologists proposing and utilizing methods of intervention in the lives of people with less and less concern for knowledge about the individual characteristics of the objects of their ministrations. While there appears to be a rising curve of progress in psychometric sophistication in personality assessment (Goldberg, 1974; Wiggins, 1973), little of this has found its way into either the training or practice of clinical psychologists. Practicing clinicians, if we are to believe

recent surveys (Garfield & Kurtz, 1973; Lubin, Wallis, & Paine, 1971), are still relying primarily upon the same assessment instruments they did twenty or more years ago, while university training programs seem to be in disarray concerning their stance toward testing and assessment.

A major reason for this situation, I would argue, is that we have come to accept a rather narrow and undifferentiated view of the assessment enterprise. As the professional literature reveals (Arthur, 1969; Goldfried & Kent, 1972; Kanfer & Saslow, 1965), many clinical psychologists have increasingly come to regard prediction in the service of therapeutic intervention as the sole purpose of assessment. But this, I would argue, is to ignore assessment's other functions which in my view, at least, should also be of concern to clinical psychologists.

Clinical and personality assessment may be shown to serve three different, but certainly related, functions. Diagnostic testing, particularly for the purpose of decision-making, prediction, and selection in various contexts, serves what may be termed assessment's discriminative function. Regardless of the test or methodology used, the ultimate purpose of this function is to provide a basis for a choice between two or more discrete courses of action.

Assessment's second function, which I would call its schematic function, serves to generate the information or framework within which the clinician can formulate and implement his intervention plans in the case of the person or group with which he is working. The product of this second function can range anywhere from a traditional psychodiagnostic work-up to the functional analysis of some problematic target behavior. Its form and content may vary, but its function, regardless of its form, is to provide a schema for the clinician - one which will help him make sense out of the behavioral phenomena presented

him by his client and one which will provide a rationale or microtheory for his intervention efforts.

There are three points that I believe require emphasis in this respect. The first is that all clinical intervention rests upon schemata of some kind and that these are generated by assessment of one kind or another. The second is that to conceive of assessment's schematic function only in terms of the use of any particular tests or assessment methods is, in effect, to close the door on forms of intervention which may require data generated by other methods. And the third is that to fail to provide proper training in this vital function of assessment is to allow our effectiveness as therapeutic agents to rest upon idiosyncratic factors to a greater extent than is warranted for a profession which claims to be a science as well.

The production of the scientific data upon which our knowledge and theories of personality, psychotherapy, and psychopathology rest is contributed to be assessment's third function - what I would call its epistemic function, its contribution to the continued growth of scientific knowledge. Whether we are interested in the effects of meditation on personality functioning, the personality characteristics of child-abusing parents, or the heritability of manic-depressive psychosis, assessment has a role to play, and I see this as clearly falling within the province of clinical psychology.

Now I would argue that much of the chaos, disenchantment, and controversy which characterizes the field of assessment can be traced to our failure to distinguish among assessment's different functions, and our frequent use of instruments that are most appropriate for one function for another for which they are considerably less appropriate,

and then damning them for their inadequacy. From this standpoint, for example, the question is not should we continue training in projective techniques, but rather for which of assessment's functions are projective techniques appropriate and for which are they not. Given the answer to this latter question a university training program and an internship center can decide which diagnostic instruments and methods they will provide training in on the basis of the functions they wish to stress in their program. Thus, I would propose that one of our first orders of business should be deciding how to apportion the responsibility between the universities and internship centers for training in each of assessment's functions and the methods appropriate to them.

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